☐ **Open Enrollment**
☐ **Open Enrollment Late Processing**
☐ **Outside Open Enrollment**

Georgia Department of Community Health
State Health Benefit Plan
Forms Transmittal Sheet

Mail with attachments to:
State Health Benefit Plan
Eligibility Section
P. O. Box 38342
Atlanta, GA 30334-0342

Payroll Location Number	
Payroll Name	
Person Submitting Report	
Phone Number	

Date Submitted to SHBP	Month	Day	Year

Transactions Reported		Number Submitted
	Terminations (Listed below)	
Coverage	Membership forms (SHBP 66-090)	
	Dependent Miscellaneous Update forms (SHBP 66-091)	
	Notification of Return from LWOP forms (SHBP 66-093)	
	Total of these three lines:	
Other	HMO (SHBP 66-006)	
	Declinations (SHBP 66-004)	
	Dependent Student Status (SHBP 66-082)	
	Other forms	

The following employees no longer have payroll deductions for health benefit coverage.

Termination Code *	Social Security Number	Employee's Name		Date of **Last Payroll** Deduction		
		Last	First	Month	Day	Year

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more then $1000 or imprisonment for not less than one and nor more than five years, or both, if I knowingly and willfully make a false or fraudulent statement or representation to the Department regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Employer Signature: _____ Date: _____

* Use these termination codes

TERM - Terminated
TRAN - Transferred Out
DISC - Discontinued
LWOP - Leave without Pay
RETR - Retired
LOFF - Laid Off
DCSD - Death of Member
RHRS - Reduced Hours